Project Age Well

16-week wellness telehealth program strengthening nutrition security and community connection for older adults in the Bay Area

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Background and Purpose

A. Goal:

The goal of Project Age Well is to provide peer connection, wellness education, individual nutrition support, and medically tailored meals to socially isolated older adults in urban and rural areas. The program seeks to understand the utility of telehealth, peer groups, and individualized support alongside medically tailored meals and groceries in promoting nutrition security, reducing social isolation and building confidence in managing health.

B. Objectives:

1) Reach 121 participants in the Bay Area.
2) Implement and evaluate a simple telehealth service linking isolated older adults in both urban and rural settings.
3) Facilitate improved health outcomes for older adults.
4) Create a more efficient host agency through the pilot testing and integration of novel approaches to engaging with client populations through the use of telehealth.

C. Overview of Project:

Project Open Hand (POH) received a 2020 Administration for Community Living Innovations in Nutrition Grant to connect socially isolated older adults and improve nutrition security in urban and rural areas throughout San Francisco, Alameda, and Sonoma Counties. Project Age Well recruited a total 115 older adults, divided into small cohorts, who participated in a 16-week class series via Zoom that covered various topics of wellness and nutrition. These topics included reducing stress, making social connections, understanding the connection of food and mood, meal timing and portions, and more. In addition to the weekly classes, participants engaged with the grant nutritionist in three individual calls throughout the program. Participants received weekly deliveries or pick-up of medically tailored meals and/or groceries from POH (San Francisco and Alameda Counties) and Ceres Community Project (Sonoma County) for the duration of the program.

D. Project Results:

- Project Age Well reached 115 older adults in the Bay Area -- 53 in San Francisco County, 34 in Alameda County, 28 in Sonoma County – who were an average of 72 years old. Seventy-five percent were female; 53% identified as white, 18% African American/Black, 14% Asian or Pacific Islander, 13% Latino/Hispanic, and 2% Other.
- Over 55% of successful referrals were from partner providers or community organizations. Another 25% self-referred via Facebook (17%) or other avenue (8%), and 12% came through word of mouth. Thirty-four percent of referrals overall resulted in enrollment. Barriers to enrollment include lack of interest in classes, illness, discomfort with technology and monolingual needs. Eighty-eight percent of those enrolled completed the 16-week program.
- Project Age Well resulted in 8,221 meals and 1,531 grocery bags served, 190 classes and 293 individual counseling sessions completed. Seventy-five percent of participants completed at least half of all classes; of those, the average number of classes completed was 13 (82%). One

hundred percent of participants completed at least one individual session, and 89% completed two or more.

- Eighty-five percent of participants joined classes using Zoom online – 82% via a computer or tablet, and 18% by smartphone. Overall, 90% of post-survey respondents reported that the Zoom technology (online or dial-in) was easy to use (Fig A).
- Eighty-three percent of participants completed a post-program survey. Of these, 98% were satisfied with their experience in Project Age Well, with 95% citing that they would recommend Project Age Well to others (Fig B). The perceived utility of the program ranged – 95% of respondents cited that services were useful in improving access to healthy foods, and 93% reported the program was useful in improving the ability to follow nutrition recommendations (Fig C). Approximately 77% reported the program was helpful in addressing feelings of loneliness or isolation. Ninety-seven percent reported that it was at least slightly helpful in improving overall health.

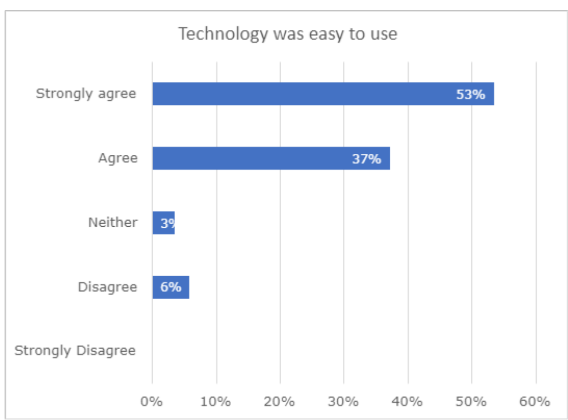
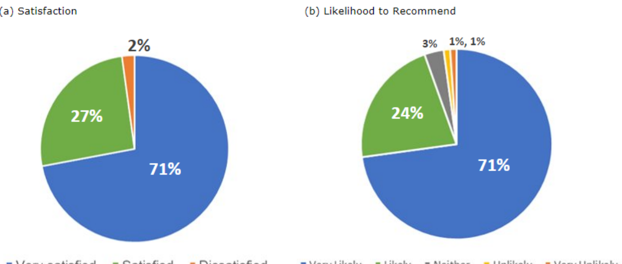


Figure A. Participant perceptions of ease of use for Zoom online or dial-in technology. Ninety percent agree the technology was easy to use. The same Zoom meeting information was used for all classes and online individual sessions. Zoom information was provided during intake calls, printed in Participant Booklets mailed to all participants and was sent in reminder emails and texts each week. For the individuals using loaned tablets, the Zoom information was programmed as a unique shortcut on the home screen. A staff member was available at the beginning of each class to troubleshoot technology issues for participants.

Figure B. Participant report of (a) satisfaction and (b) likelihood to recommend Project Age Well.



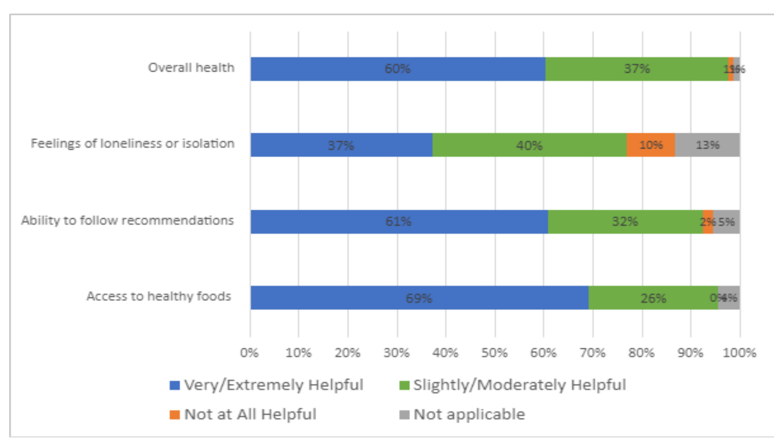


Figure C. Respondent perceptions of how useful Project Age Well services were in improving access to nutritious foods, ability to follow dietary recommendations, ability to address feelings of loneliness or social isolation, and overall health. As part of this innovation grant, the approach to building social cohesion and providing support for social connection evolved in response to early participant feedback. For example, time in breakout rooms were extended, additional opportunity for free discussion integrated, and Facebook group and informal Zoom meetups for alumni added.

Partners and Project Staff

A. Partners:

- **Project Open Hand (POH):** A medically tailored meal and grocery nonprofit organization based in San Francisco and Alameda counties that hired the staff members necessary to execute this project. It also provided 16 weeks of meals and/or groceries for the 87 participants living in San Francisco and Alameda counties for Project Age Well.
- **Ceres Community Project:** A medically tailored meal nonprofit organization based in Sonoma and Marin counties that provided meals and/or groceries for the 28 participants living in Sonoma County for the 16 weeks as part of Project Age Well.
- **Continuud**: This technology service provided tailored interfaces and maintenance for tablets that participants were able to access in the case that they did not have a device to use for Project Age Well telehealth programming.

B. Project Staff Roles:

a. List number of FTEs
   - 2.5 FTEs

b. List staff title and general responsibilities

   - **Project Manager:** Oversight of entire project, including managing Project Registered Dietitian Nutritionist and Project Intern, developing communication and advertising materials, analyzing project results, writing monthly reports, managing budget, facilitating meetings, co-facilitating classes.
   - **Project Registered Dietitian Nutritionist:** Recruiting participants, developing communication and nutrition class materials, providing individual nutrition support for participants, facilitating and co-facilitating classes, liaising participant communication and needs, contributing to participant Facebook page.
   - **Care Coordinator:** Recruiting participants, developing wellness class materials, providing individual support for participants, facilitating and co-facilitating classes, liaising participant communication and needs.
   - **Project Intern:** Assisting with initial calls to interested participants, helping participants complete program surveys, conducting interviews with staff to glean program insights, developing FAQ for Capstone Report.
   - **IT Support:** Assisting with technical needs of project staff, including audio, video, VPN connection, Zoom, and tablet needs.
   - **Communication Support:** Helping with advertising on Project Open Hand website as well as Facebook ads.

Funding and Sustainability

A. Initial Funding:

- 2020-2023 Administration for Community Living Innovations in Nutrition Grant
- POH In-Kind Match includes staff time for recruitment and administrative support, proportion of meals and grocery cost, volunteer time to prepare meals and groceries.

B. Continued Funding:

- Content from the Project Age Well curriculum will be used in quarterly education sessions offered as a component of Project Open Hand's congregate nutrition program operated at twelve sites in San Francisco. This is funded by the San Francisco Human Service Agency's Department of Disability and Aging Services.
- Content will also be used in monthly nutrition education sessions offered as part of a contract supporting people living with diabetes and/or heart disease also funded by the San Francisco Human Service Agency's Department of Disability and Aging Services.
- We are considering building this curriculum and telehealth, peer group approach into future contract renewals, such as the Ryan White HIV/AIDS Program.

C. Sustainability:

External Use and Collaboration

- Sharing results, lessons learned, and considering replication within the greater Food is Medicine Coalition. The team presented Project Age Well at the Food is Medicine Coalition Symposium in September 2023 in collaboration with fellow INNU grantee, Open Hand Atlanta, in hopes of encouraging other organizations to adopt similar models of programming, continue to refine, test reproducibility, and outcomes of self-management curricula.
- We see promise in Project Age Well curriculum contributing to the existing body of self-management curricula. After additional applications of the curriculum with older adult populations and establishing an evidence base for its use, we may consider submitting the curriculum for accreditation.

Internal Integration of Project Age Well Approaches

- We will provide ongoing social meet up opportunities. Project Open Hand will continue to host monthly, 45-minute, informal Zoom meetups for Project Age Well alumni as well as their greater population of clients. The focus of these meetups is to serve as a point for social connection; they involve breakout room discussions, games, trivia, stretch breaks, and more. We have realized that these meetups are relatively easy for staff to prepare and advertise for and serve as a real boon and point of connection for participants.
- POH will use the Project Age Well curricula as a regular part of the education for other POH contracts. Many staff members across the Nutrition and Client Services teams had the opportunity to observe Project Age Well classes (at least 13 different classes!) to both identify which classes are most relevant to our greater population of clients and to begin to cross train.

We hope to offer a consistent curriculum series for subpopulations of POH clients. We will consider methods for screening and/or recruiting clients into this program for support.

- Scheduling incoming POH clients with an appointment time to meet with the Registered Dietitian. In Project Age Well, we found it very helpful to schedule appointments with participants for intake calls as well as individual calls as opposed to cold calling participants to complete either of these. Once we scheduled a time with participants, we sent a confirmation e-mail that day as well as a reminder e-mail and/or text message the day prior. At present, the Nutrition Services team cold calls any client in need of nutritional counseling, which has become very burdensome and unsustainable. Thus, POH plans to implement the lesson learned from Project Age Well in scheduling clients for a visit with a Registered Dietitian in their initial intake call with client services team staff member.
- Adding a goals and resources tracking mechanism to POH's new Client Database. The Project Age Well team designed and employed a tracker in which we noted goals and resources that we shared with every participant. This tool was transformative in being able to provide more quality and comprehensive care and follow up as well as the ability to note participant progress and evolution. With encouragement from the Project Age Well team, POH is considering the integration of this tool into the database in development.

Recruitment

A. Participants

a. Eligibility Requirements

- Adults ages 60 years and older
- Living in San Francisco, Alameda, or Sonoma County
- English speaking
- Self-identified need for social connection
- Desire for food support
- Ability to store and heat food

b. What recruitment methods were used?

Successful | *Methods*:

- Targeted advertising through Facebook. This was highly effective and was our primary source of incoming referrals in San Francisco and Alameda counties (approximately 36% of successful referrals in Alameda). We kept the copy clear, direct, and compelling. We also targeted our ads to certain zip codes, age groups, and interests. We linked to a basic interest form and provided our contact information for direct inquiries. Facebook advertising allowed participants to find us directly and express interest. This method of self-referral was fundamentally different from any strategy POH has implemented in the past.
- Reaching out to community partners with presentations and e-mail blasts, including presentations for Alameda Alliance for Health, local Area Agency on Aging organizations, Little Brothers Friends of the Elderly, etc. and e-mail blasts to a variety of community partners. These presentations and e-mail blasts then prompted social workers, case managers, and other care providers to refer participants to Project Age Well. This method seemed to be successful due to strong existing relationships with community partners as well as effective communication and compelling storytelling in the presentations.
- Spreading through word of mouth amongst current participants. Participants would share the word with family members, neighbors, and friends or post flyers in their buildings to advertise Project Age Well.
- Receiving internal referrals from clients timing out of other POH programs. When POH clients were no longer eligible for meals through other contracts, Client Services staff members would refer them to Project Age Well, as relevant.

Successful | *Adjustments to Eligibility and Program Components*:

- Dropping the need for any specific health diagnosis greatly widened the number of eligible participants.
- Allowing for groceries as an option versus only prepared meals; some participants did not want meals, but still wanted to participate in the program. Groceries were a huge help as an alternative option to meet participants where they are with their needs and preferences.

- Establishing defined cohorts: When we initiated participants into a cohort of participants, they felt a sense of connection and with that, a sense of responsibility to keep showing up. Being able to work with defined cohorts helped with retention.

Less successful | *Methods:*

- Distributing flyers at POH Congregate Meal Sites. We utilized this method early on when trying to start recruitment; it was very difficult to encourage people to sign up in person.
- Distributing flyers at older adults housing sites and other community sites. Despite staff posting flyers in creative and relative spaces to older adults, this resulted in very few interested participants.

B. Volunteers or Students, if used

Not applicable for this project

C. Marketing Tips

Successful:

- Targeted advertising through Facebook. This was highly effective and was our primary source of incoming referrals in San Francisco and Alameda counties (approximately 36% of successful referrals in Alameda). We kept the copy clear, direct, and compelling. We also targeted our ads to certain zip codes, age groups, and interests. We linked to a basic interest form and provided our contact information for direct inquiries. Facebook advertising allowed participants to find us directly and express interest. This method of self-referral was fundamentally different from any strategy POH has implemented in the past.

Not Successful:

- Distributing flyers at POH Congregate Meal Sites, housing sites and community sites. We utilized this method early on when trying to start recruitment; it was very difficult to encourage people to sign up in person. Despite staff posting flyers in creative and relative spaces to older adults, this resulted in very few interested participants.
- Walgreen's display window advertisement. This resulted in very few interested participants and was not worth the cost of professional printing for display materials.

Tools

A. Technology

- **Zoom application:** We used the Zoom platform to conduct our weekly remote classes; participants were able to access by dialing in or by using audio/Click here to enter text.video through a smartphone, tablet, or computer.
- **Samsung tablets with 4G data:** We offered tablets to participants in need of a device for which to connect to classes. Continuud was the contractor who provided the tablets and support.
- **Asana:** We utilized Asana for project management to track the evolution of interested participants to enrolled participants as well as to track teaching schedules.
- **Microsoft Suite:** We employed Microsoft Word, Excel, PowerPoint, Outlook, Teams, and OneNote for various project needs.
- **Project Open Hand's Proprietary Client Database:** We relied on this to store client contact information, record nutrition assessment notes, and to facilitate POH meal and/or grocery delivery or pick up.

B. Resources

- **Internal mailing service**: We utilized POH's existing internal mailing service to mail participant handouts, workbooks, tablets, and any other relevant printed information.
- **H&H Printing:** We worked with H&H Printing to print, collate, and bind our project workbooks to be able to distribute to Project Age Well participants in Alameda and Sonoma counties.

Project Timeline

2020

Summer 2020 (June, July, August)

- Submitted grant proposal for 2020 ACL Innovations in Nutrition Grant.

Fall 2020 (September, October, November)

- Received ACL Innovations in Nutrition Grant.
- Identified, hired, and onboarded Program Manager and Care Coordinator.

2021

Winter 2020-2021 (December, January, February)

- Identified, hired, and onboarded a Registered Dietitian Nutritionist.
- Collaborated with San Francisco County partners to develop a client referral pipeline.
- Developed nutrition and wellness curricula.
- Created pre-program and post-program surveys for evaluation.

Spring 2021 (March, April, May)

- Continued developing nutrition and wellness curricula.
- Assessed and addressed database and technology needs.
- Continued collaborating with San Francisco (SF) County partners to develop client referral pipeline.
- Began accepting referrals via pipeline established with SF partner agencies (continued through May 2022).
- Conducted first intake and baseline assessments (continued through May 2023).
- Administered pre-program surveys to incoming participants (continued through May 2023).
- Identified, hired, and onboarded a new ACL Grant Nutritionist.

Summer 2021 (June, July, August)

- Launched 16-week class series for 1st group of participants.
- Offered individual calls with Nutritionist and/or Care Coordinator to all participants (continued in the first three weeks of all new cohorts, through June 2023).

Fall 2021 (September, October, November)

- Launched second 16-week class series.
- Distributed first post-program surveys to the initial cohort of participants (continued during weeks 15-16 for all participants completing the program, through August 2023).
- Developed and initiated use of Asana for client and project management.

2022

Winter 2021-2022 (December, January, February)

- Conducted review of curriculum and implemented edits and changes in approach (through August 2022).
- Initiated discussions with Little Brothers Friends of the Elderly, a substantial referral source for San Francisco programming.
- Launched third 16-week class series. Adjusted to a rolling admission approach.
- Shifted Project Manager responsibilities when an internal promotion occurred.

Spring 2022 (March, April, May)

- Launched first Facebook campaign and enrolled first online self-referral participants.
- Launched fourth 16-week class series. Began offering classes Tuesday and Wednesday of each week.
- Began collaborative discussions and presentations with Alameda County partners to develop client referral pipeline for Alameda County launch in October 2023 (continued through November 2023).

Summer 2022 (June, July, August)

- Launched final SF 16-week class series. Classes take place Tuesday – Thursday.
- Submitted revision to work plan to adjust timeline and overall reach.

Fall 2022 (September, October, November)

- Identified, hired, and onboarded a new Registered Dietitian Nutritionist.
- Closed out San Francisco County cohorts, including distributing post-program surveys and evaluation.
- Created and posted targeted Facebook advertisements for Alameda County.
- Accepted referrals via pipeline established with partner agencies in Alameda County and self-referrals via Facebook advertisements or word of mouth.
- Launched two 16-week class series in Alameda County – Cohort 1 in October 2022 and Cohort 2 in November 2022.
- Initiated program planning and workflow discussions with Ceres Community Project for Sonoma County.

2023

Winter 2022-2023 (December, January, February)

- Launched 16-week class series in Alameda County with Cohort 3 (final Alameda County cohort) in December 2022.

Spring 2023 (March, April, May)

- Closed out Alameda County cohorts, including distributing post-program surveys and evaluation.
- Posted targeted Facebook advertisements for Sonoma County.
- Accepted referrals via pipeline established with Ceres Community Project and self-referrals via Facebook advertisements.
- Launched three 16-week class series in Sonoma County – Cohort 1 in March 2023, Cohort 2 in April 2023, and Cohort 3 (final Sonoma County cohort) in May 2023.
- Analyzed results from Alameda County post-program surveys.
- Began preparation of appendix items for Capstone Report.

Summer 2023 (June, July, August)

- Closed out Sonoma County cohorts, including distributing post-program surveys and evaluation.
- Initiated discussions of synergies with Open Hand Atlanta, fellow INNU grantee, and planning for potential replication and adoption of novel approaches.
- Included Project Age Well approaches in FY24 strategic planning discussions for Programs and Nutrition teams at Project Open Hand.

Fall 2023 (September, October, November)

- Analyzed results from Sonoma County post-program surveys. Completed full program evaluation.

Frequently Asked Questions

Q: Do participants have to have a specific medical diagnosis to participate in Project Age Well?

A: The eligibility criteria for Project Age Well in your context will depend on what your organization is currently funded to serve. For example, the iteration of Project Age Well described here was available to older adults independent of medical diagnosis, as the funds from the Administration for Community Living covered a significant proportion of meal service and staff time. Be sure to investigate your existing funding, staffing, and (if relevant) meal service model and proactively plan for the population you would like to target.

Q: Were clients engaged for the full sixteen weeks? Was participation in Project Age Well flexible?

A: Participants were able to participate in a variety of ways, as determined by their needs and preferences. For the purposes of evaluation of this project, completion was defined as either (a) attendance at 50% of classes and at least one individual session or (b) engagement in all three individual sessions. All participants accessed meals and/or groceries for the length of the program. We found that certain individuals were looking for more one-on-one support for achieving goals or accessing resources, while others were seeking regular social support and group-based wellness education. Flexibility in engagement was supportive of helping us reach 88% completion. We are looking at variations of this program that may include shorter timeframes and other configurations of participation. All of these should be rooted in an understanding of the population served and allow for client choice whenever possible.

Q: Is the Project Age Well curriculum available in multiple languages?

A: Currently, the curriculum and related materials (ex, participant workbook) are available in English only. The team would like to see this curriculum translated to Spanish in the next iteration and recommends translation for relevant languages as well as a review of content and relevant community resources appropriate for individual communities.

Q: Can Project Age Well be implemented in-person as well?

A: Yes! The materials and approach to Project Age Well can work for in-person settings. Class PowerPoint slides can be shared on any display, and participant workbooks are available for in-person discussion and group collaboration. Hybrid events may be planned as well to allow local and remote participation. Individual sessions can be conducted in-person in private settings. You can view the facilitator guide, lesson plans and class materials to help prepare for implementation in a variety of settings.

Q: What were the challenges in using telehealth technology for this Project Age Well?

A: One of the biggest challenges was the limited recruitment of populations who would likely be best served by connecting online because of limited familiarity with or interest in using technology. The conversion rate for Project Age Well was 34%, and some of this was related to discomfort with technology at the outset. We needed to be clear about the dial-in option when promoting the program. One way to address this would be to partner with an organization that supports digital literacy for older adults. If someone lacks a device but has knowledge and interest, partnering with an organization or providing loaner devices can provide access support. Once enrolled, 86% of participants agreed that the technology was easy to use. This is likely attributed to (a) participant familiarity with Zoom and device use, (b) flexible participation via video, audio, online or dial-in, and (c) support staff who joined each class for the first 15-20 minutes to identify those who need support and follow up by phone.

Frequently Asked Questions *Continued*

Q: What was your biggest challenge in implementing Project Age Well overall?

A: Recruitment was a challenge for the first year of the program, when we were primarily focused on community partners and internal staffing to keep up the momentum. These partnerships were critical, but we also struggled with staffing changes at various AAA's, loss of contact or competing priorities for services supporting older adults. Our most successful community partnerships went beyond in-service presentations to include co-designed workflows for recruitment and enrollment and monthly checks on progress. We found that Facebook self-referrals were an efficient way to engage with potential participants. The limitation with this approach would be in the instance of strict medical eligibility criteria that require follow-up with a provider.

Q: Does a team need a registered dietitian nutritionist (RDN) on staff to implement Project Age Well?

A: The components of Project Age Well do not require that a registered dietitian nutritionist lead their implementation, per se. Nutrition classes are designed to be led by anyone with a background in nutrition but could be successfully implemented by a staff member who is trained by a RDN or related professional. That said, questions about specific medical conditions and medical nutrition therapy should be directed to RDNs.

Q: What if my organization does not have a medically tailored meal or grocery program?

A: There are several options for implementing Project Age Well in your community if you do not have a medically tailored meal or grocery program. You might consider partnering with a meal provider in your region such as one of the many Food is Medicine Coalition organizations across the country; visit this site to learn more: https://www.fimcoalition.org/partners. For example, we were able to partner with Ceres Community Project, a food is medicine organization serving Marin and Sonoma counties, to provide meals outside of our service area while we led the class instruction and individual sessions. You might also consider implementing the class series for peer groups and individual sessions alone with a focus on helping connect older adults with existing resources in their community, such as SNAP benefits, food pantry delivery services and in-home support services.

Q: How effective was using the UCLA 3-Item Loneliness Scale in evaluating Project Age Well?

A: The UCLA 3-Item Loneliness Scale was included in both pre- and post-program surveys. For program evaluation, the responses were useful to qualify that we were indeed reaching a target population that is experiencing some measure of loneliness. However, the ability to capture changes in self-reports of loneliness is limited. The utility of this scale was most pronounced as a screening tool for identifying those for whom follow up regarding social support needs and goals would be most relevant. Responses to the three questions provided a starting point for conversations during the first individual counseling session.

Advice for Replication

1. Think through the **use of technology** thoroughly and provide consistent tools, early support and flexible options for participation. Everyone has a unique level of comfort with and interest in Zoom, smart devices, computers, etc. Being clear from the point of outreach through enrollment that there are multiple ways to engage with the program and providing hands-on support to establish a sense of clarity and confidence at the outset will improve both enrollment and completion rates and provide a more fulfilling participant experience. Four steps we took include (a) assessing level of comfort and need for support during intake, (b) establishing one Zoom meeting for use for all engagements throughout the program, and reiterating this information often, (c) providing tablets (Continuud) to interested participants, and (d) structuring classes and materials to support those joining by phone on Zoom.
2. Assess your population and their **needs and preferences** prior to tailoring and launching Project Age Well in your community. Be clear about who you would like to target and conduct listening sessions or other types of data gathering to inform priority topics, languages for translation, approaches for support and ways to best structure class and individual session time. When doing this, be clear about the goals of the program regarding nutrition security and social isolation to help your participants fully understand and engage with Project Age Well programming.
3. Create strong **connections with community nutrition and wellness resources/partners** as both a compliment to Project Age Well services and for support with recruitment. Project Age Well is designed to guide participants to tools and resources in communities around them, and providing warm handoffs to these resources will deepen the impact of Project Age Well during and beyond the 16 weeks of programming. Allow substantial time and follow-up to onboard partners to Project Age Well and allot sufficient staff time to provide support for recruitment and workflow development with these partners.
4. "**Utilize all forms of communication** to best meet the participants where they are and encourage consistent participation." (Erika Tribett, Project Age Well Project Manager): Consider adopting a HIPAA compliant method of texting and emailing participants for anything from recruitment to sending class reminders, to follow-up emails created from a template. Ask participants at the outset which method of communication they prefer. While participants may be open to telehealth for accessing classes and counseling, they may prefer mail versus email for handouts or resources!
5. **"Less is more."** (Sami Wilkinson, Project Age Well Care Coordinator): For overall program effectiveness, narrow the breadth of curriculum to the topics that are most relatable to one another and for which you possess the most knowledge. Avoid overcomplicating logistics and have a consistent class approach.

Appendix List

Outreach and Recruitment

B1. Project Age Well flyer - Flyer for print and distribution for recruitment. –

B2. Project Age Well Facebook advertisement – Simple, targeted advertisement for use on Facebook ads.

Client Services Materials

B3. Intake Procedure – List to support care coordinator or similar role in gathering participant information and orienting participant to program details.

B4. Participant Tracker – Simple Excel workbook used to organize and track participation in Project Age Well.
B5. Participant Management Checklist – Comprehensive to-do list for engaging with participants throughout Project Age Well.

Participant Correspondence

B6. Welcome to Project Age Well (email) – Template for use after intake call, prior to first class.

B7. Class reminder (email) – Template for use day prior to upcoming Project Age Well class.

B8. Class reminder (text) - Template for use the day prior/morning of an upcoming Project Age Well class.

B9. Individual session reminder (email) - Template for use day prior to upcoming individual session.

B10. Individual session follow-up (email) - Template for use after an individual session.

B11. Project Age Well transition (email) - Template for use following the final Project Age Well class.

Individual Session Support

B12. Individual session script – Outline for conducting a nutrition and wellness session with individual participants.

C1. Goals and resources tracker – Tool for use during individual sessions to capture participant goals, resources needs and perceived progress throughout the course of Project Age Well.

Participant Materials

D1. Participant workbook – Comprehensive program information, interactive class handouts, resources and recipes for use in all Project Age Well classes and as reference during and after the program. (Sleep log)

Facilitator Materials

E1. Facilitator guide - Guidance for how to successfully implement Project Age Well classes, independent of topic.

Lesson Plans and Slides, by Topic

Nutrition Topics

Lesson Plans found in Appendix A.

Slides for the following - reach out to grantee.

1. Eating well 101
2. Variety of Fruit and Vegetables
3. Meal Timing and Portions
4. Quality and Food Labels
5. Meal Planning for Savings and Wellness
6. Cooking for Wellness
7. Food & Mood
8. Our Bodies and Nutrition as We Age

Wellness Topics

Lesson Plans found in Appendix A.

Slides for the following - reach out to grantee.

1. Developing Healthy habits
2. Building Social connection
3. Reducing Stress & Cultivating Mindfulness
4. Protecting Your Brain Health
5. The Power of Sleep
6. Preventing Falls
7. Maintaining Mobility
8. Taking Charge of Your Health Care

Ongoing Participant Engagement

B13. Alumni meet-up sample slides (summer theme) - Template used for 45-minute, informal Zoom meetups for Project Age Well alumni, including breakout room discussion topics, stretch break and games.

B17. Facebook group – Outlines Facebook group settings, about information, group rules and sample topics.

Survey Tools

B14. Project Age Well class feedback survey – Brief survey to assess quality of classes and facilitation as they are developed and key takeaways for participants.

B15. Project Age Well post-program survey – Survey to assess program satisfaction as well as perception of quality of life, food security, loneliness, and confidence in health management.

B16. Project Age Well baseline survey – Survey to assess baseline quality of life, food security, loneliness, confidence in health management, and goals.